2017

Columbia Gorge Regional Community Health Improvement Plan

COLLABORATING FOR OPTIMUM HEALTH AND OPTIMIZED HEALTHCARE

Table of Contents

About the Region

The Columbia Gorge Region is comprised of seven counties and lies on both sides of the Columbia River. In Oregon, the Columbia Gorge region is represented by Hood River, Wasco, Sherman, Gilliam, and Wheeler counties. Skamania and Klickitat counties make up the Washington side of the region. These counties cover 10,284 square miles and are home to a population of approximately 84,000.

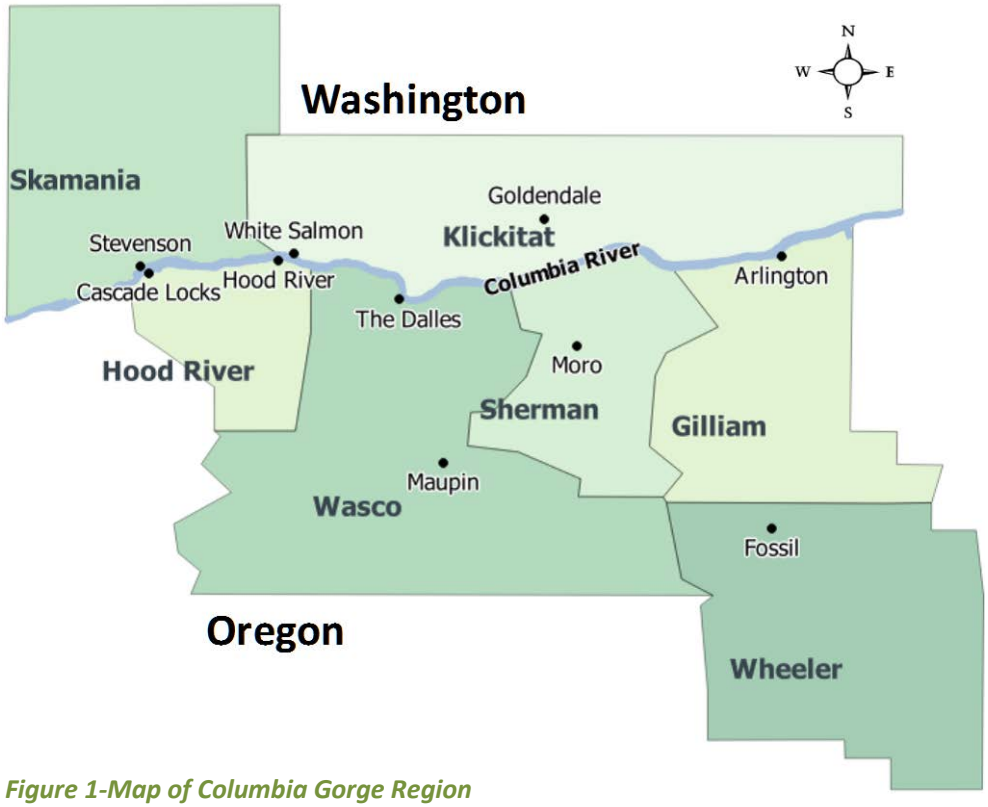


Figure 1-Map of Columbia Gorge Region

The Columbia Gorge Region is mostly rural with only a few towns that are larger than 1,000 people. Agriculture is a large industry in almost every county. Tourism, healthcare, forestry, and growing technology firms also drive the economy. Many of our industries rely on seasonal employment. Therefore, we experience a large influx of workers, especially migrant and seasonal farm workers and Native American populations during fishing seasons.

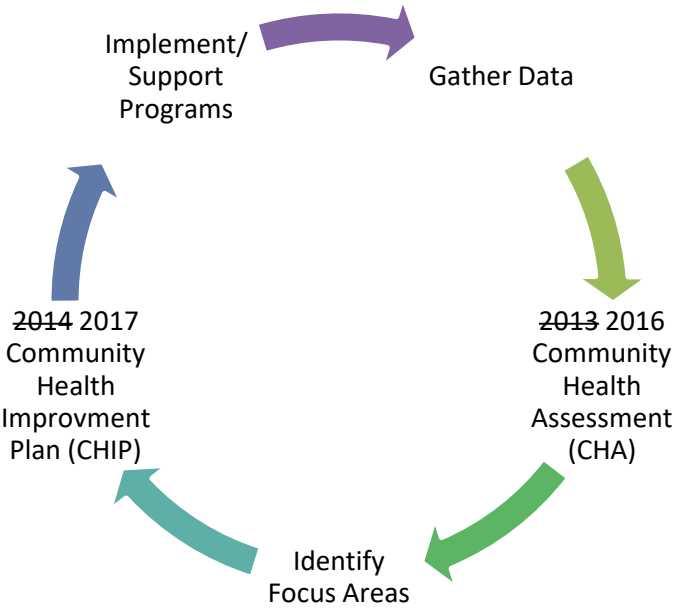
Columbia Gorge Community Advisory Council

The Community Advisory Council, or CAC, is comprised of Medicaid consumers, community members, and local organizations. Their mission is to give the community a voice so that the consumer and community health needs are heard. They provide feedback on current services and programs and give their input on new program ideas. They also help connect organizations which in turn improves community connectedness.

The CAC oversees the development of the regional Community Health Assessment – an effort that happens every three years. The CAC played an integral role in reviewing, refining and crafting questions for the community survey as part of the 2016 Community Health Assessment. The full description for the 2016 Community Health Assessment can be found at: http://cghealthcouncil.org/documents/

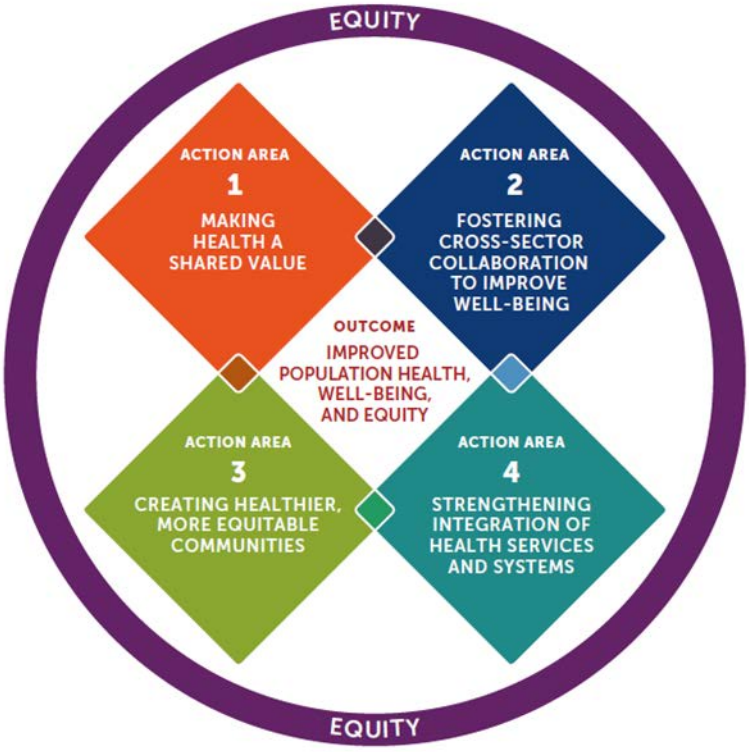
The Community Health Assessment process was recognized in 2016 when the Columbia Gorge Region was awarded the Robert Wood Johnson Foundation (RWJF) Culture of Health

Prize. This prestigious recognition further engaged the community in a conversation on what defines health and measurements for monitoring progress towards health.



Using the 2016 Community Health Assessment, the CAC identified focus areas that represent the highest need areas from the CAC point of view. This document represents the second iteration of the Community Health Improvement Plan (CHIP). With a community-endorsed CHIP, the CAC supports proposals and programs from local organizations to address areas highlighted in the CHIP. The cycle shown at the right is repeated every three years.

During the development of the 2017 Community Health Improvement Plan (CHIP), the Gorge region was introduced to the RWJF Culture of Health Action Framework.



The Culture of Health Action Framework provides a shared language and a shared measurement system - both of which are cornerstones of the Collective Impact work to create a healthy community.

For the 2017 CHIP, the Community Advisory Council adopted the Action Framework. Using the framework, the CAC selected three focus areas – known as ***Drivers*** in the Culture of Health Action Franmework. The CAC will focus its efforts and resources on these Drivers identified later in this document. The CAC believes that all of the drivers in the framework are important encourgaes other sectors in the community (business, education, governmental, non-profits, etc.) to identify their own focus areas using the same framework. The overall goal is to create a healthy community through our collective efforts across all sectors.

Robert Wood Johnson Foundation Culture of Health Action Framework

Our health is greatly influenced by complex factors such where we live, and the strength of our families and communities. The Robert Wood Johnson Foundation proposed a vision for a national Culture of Health where everyone has the opportunity to live a healthier life.

Developed in collaboration with the RAND Corporation, the Culture of Health Action Framework sets an agenda to improve health, well-being, and equity. It contains three core elements:

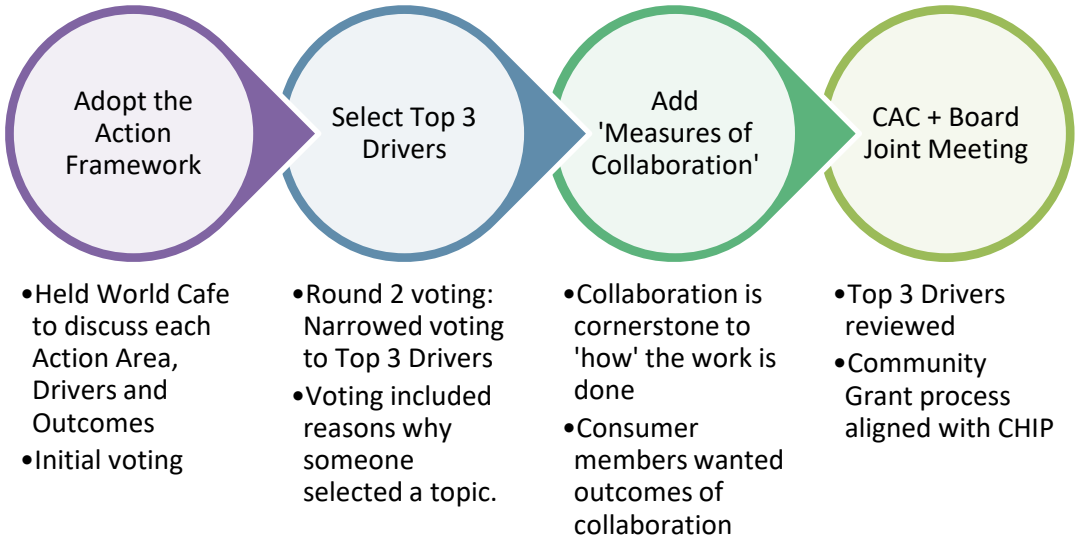
- *Action Areas*: high-level objectives which can improve population health, well-being and equity;
- *Drivers*: activities or systemic factors that are critical to achieving better health; and,
- *Measures*: specific social, economic and policy data points that can help track progress over time.

The Action Framework is informed by rigorous research on the multiple factors which affect health. It recognizes there are many ways to build a Culture of Health, and provides numerous entry points for all types of organizations and communities to get involved.

For more information about the RWJF Action Framework visit this link:
http://www.rwjf.org/en/how-we-work/building-a-culture-of-health.html

2017 Community Health Improvement Plan Process Overview

Over a 5-month process, the CAC adopted and adapted the RWJF Action Framework to meet the local needs. The result was a selection of three Drivers across the framework with local additions for measures reflecting outcomes of effective collaboration.



Using the Culture of Health Framework, the 2017 Community Health Improvement Plan includes 3 Drivers: Sense of Community, Built Environment/Physical Conditions and Access.

Driver 1.2 Sense of Community – part of MAKING HEALTH A SHARED VALUE

Research suggests that individuals who live in socially connected communities—with a sense of security, belonging, and trust—have better psychological, physical, and behavioral health, and are more likely to thrive. If people do not see their health as interdependent with others in their community, they are less inclined to engage in health-promoting behaviors or work together for positive health change.

To assess sense of community in the Columbia Gorge we must look at several measures. These measures include how emotionally connected people feel and how strong their sense of belonging to their community is. It also includes how much social support people have in their lives. Finally, collaboration with healthcare providers and social services is an important measure in ensuring a stronger sense of community.

General Measure	Gorge Definition	2016 Status
 **Sense of Community -** Aggregate score on two subscales of the Sense of Community Index: emotional connection to community and sense of belonging to community	2016 CHA: Percentage of population that feel people in their community are willing to help, can be trusted, and that feel safe in their community	2016 CHA Data: Neighborhood cohesion is about the place where people live. • People in my community are willing to help – 87% • People in my community can be trusted- 77% • I feel safe in my community- 89%
 **Social Support -** Percentage of people noting they have adequate social support from partner, family, and friends	2016 CHA: Percentage of people that think they have someone available to: love them and make them feel wanted, give good advice about a crisis, confide in or talk to about problems, and help if they were confined to a bed. The percentage of caregivers who feel they have adequate support.	2016 CHA Data: Social support reflects how often individuals have someone to be available for life circumstances. The percentages are for replies of Most or All the Time. • Love you and make you feel wanted- 79% • Give good advice about a crisis- 78% • Confide in or talk to about problems- 74% • Get together with for relaxation – 71% • Help if you were confined to a bed- 71% 20% of the population is in some form of a Caregiver role. Of that group, 40% indicate they have adequate support.

General Measure	Gorge Definition	2016 Status
Effective referrals - Clients indicate organizations have knowledge of community resources and able to refer appropriately (local addition)	2016 CHA: Percentage of cross-organization referrals based on service type and frequency of closed-loop referrals.	2016 CHA: Organizations indicated that they refer to the following organizations Regularly, Often or Sometimes and closed-loop communication is Excellent, Good or Satisfactory Service Type — Refer Rate — Closed-Loop • Primary Care — 82% — 51% • Dental Care — 68% — 29% • Mental Health — 83% — 43% • Public Health — 72% — 60% • Food — 76% — 37% • Transportation — 84% — 37% • Housing — 74% — 36% • Other — 76% — 52%

Community Listening Sessions – Local voices about this Driver and the barriers they face

[Results to be provided later]

Driver 3.1 Built Environment/Physical Conditions – part of CREATING HEALTHIER, MORE EQUITABLE COMMUNITIES

The built environment—or the physical space in which we live, learn, work, and play—is key to a community's well-being. For example, sidewalks in good condition and active transport routes, such as bicycle lanes, are features of the physical environment that may provide greater access to exercise and healthy food options. However, to take advantage of these opportunities, it's essential that we feel safe in our neighborhoods, parks, and schools.

To assess the build environment/physical conditions in the Columbia Gorge we must look at several measures. These measures include housing affordability and ease of access to healthy food. It also includes how safe youth feel in the community. Finally, collaboration with healthcare providers and social services is an important measure in creating a better built environment.

General Measure	Gorge Definition	2016 Status
 **Housing Affordability -** Percentage of families spending 50 percent or more of monthly income on housing costs for either rent or mortgage.	2016 CHA: Percentage of families that are housing burdened or paying more than 50% of their income on housing. Percentage of households feeling at risk of losing housing.	2016 CHA Data: Approximately 28% of region pays more than 30% and is on the edge or is paying more than 50% of income on housing. 10% went without Housing 22.6% are worried about losing their housing or have no stable housing.
 **Access to Healthy Foods** - Percentage of the population with limited access to healthy foods	2016 CHA: Percentage of population that had to go without food Percentage of population having 2 or more servings of fruits or vegetables per day	2016 CHA Data: 12.2% of the population went without food. 51% have 2 or more servings of fruit 64% have 2 or more servings of vegetables
 **Youth Safety** - Percentage of middle and high school students who reported feeling safe in their communities and schools	2016 CHA: Percentage of people feeling that Adults watch out for children; Percentage of students not attending school because they do not feel safe; percentage of teens report being bullied	2016 CHA Data: Neighborhood cohesion is about the place where people live. • You can count on adults in this community to watch out that children are safe and don't get in trouble – 80% Teens not attending school because they feel unsafe - 6.4% Teens report being bullied - 27.3%

General Measure	Gorge Definition	2016 Status
Equity in Physical Activity Opportunities – All neighborhoods have spaces for physical activity (local addition)	Using elementary schools as the definition of a neighborhood, obesity rates across elementary schools	Unknown for the region at this time
Mobility and Transportation - percentage who have safe access to sidewalks, bike lanes, bus or transportation (local addition)	2016 CHA: Percentage having transportation as a barrier; Percentage going without healthcare due to transportation	2016 CHA Data: 12% of the population indicate that they go without Transportation when really needed due to financial hardship Transportation was the barrier for 6-8% of the population who did not get all the care they needed.

Community Listening Sessions – Local voices about this Driver and the barriers they face

[Results to be provided later]

Driver 4.1 Access – part of STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS

Several factors influence access to health services, including the expansion of health insurance coverage. But access must be more than having insurance. It must include being able to get comprehensive, continuous health services when needed and having the opportunity and tools to make healthier choices.

To assess Access to health services in the Columbia Gorge we must look at several measures. These measures include the percent of people using primary care, mental health, and dental services. It also includes the percent of the population with stable health insurance. Finally, collaboration with healthcare providers and social services is an important measure in ensuring good access to services.

General Measure	Gorge Definition	2016 Status
 **Access to Comprehensive Primary Care –** Percentage of population (regardless of insurance) who utilize a comprehensive patient-centered primary care home health system.	2016 CHA: Percentage of the overall population that state they had a primary care visit and got all the services they needed.	2016 CHA Data: 58% of the entire population reported receiving Primary Care and receiving all care they needed. Nearly 1 in 4 of Adults and Teens did not utilize Primary Care at all. Of those utilizing primary care, one in five did not get all the care they believe they needed.
 **Routine Dental Care -** Percentage of people who report a dental visit in the calendar year	2016 CHA: Percentage of the overall population that state they had a dental care visit and got all the services they needed.	2016 CHA Data: 39% of the entire population reported receiving Dental Care and received all the care they needed. Nearly 1 in 3 of the entire population indicate that they did not need any Dental Care. Of those utilizing dental care, 30% did not get all the care they believe they needed.
 **Access to Mental Health Services -** Percentage of people who report having mental health or substance abuse problems, and who received treatment	2016 CHA: Percentage of population who needed mental health services and got all the care the needed. Note: This is different than Primary Care and Dental Care	2016 CHA Data: Overall, 20% of the population stated that they needed Mental Health Services yet 35% indicate that they have a mental condition of some sort. Primary Care is the most frequent place services are accessed followed by County Mental Health Clinic. While 8.5% of the total population did not get the services they needed, it means of those who needed services 42% did not get the services they needed.

General Measure	Gorge Definition	2016 Status
Access to Stable Health Insurance - Percentage of population, with stable health insurance, or no change in the source of health insurance	2016 CHA: Percentage of population with stable health insurance for 12 months	2016 CHA Data: Just over 82% of the population had insurance for 12 months. Of the population eligible for both Medicare and Medicaid, only 25% indicated that they had both. Approximately 8.5% remain uninsured.
Collaboration on Information Sharing - the number of times people unnecessarily repeat their information across organizations	2016 CHA: Rate of care coordination for shared patients; Rate of repeated assessments due to lack of information sharing	2016 CHA Data: For shared Patients, care coordination happens Always or Often about 1/3 of the time. When sending referrals, organizations have to Repeat Assessments Always or Often about 15% of the time because information is not shared. Care Coord / Repeat Assess • Primary Care 47% 18% • Dental Care 20% 7% • Mental Health 35% 22% • Public Health 36% 16% • Food 35% 8% • Transportation 40% 11% • Housing 27% 8% • Other 36% 19%

Community Listening Sessions – Local voices about this Driver and the barriers they face

[Results to be provided later]

ACTION AREAS	DRIVERS	MEASURES
1 MAKING HEALTH A SHARED VALUE	1.1 MINDSET AND EXPECTATIONS	Value on health interdependence Value on well-being Public discussion on health promotion and well-being
	★ 1.2 SENSE OF COMMUNITY	Sense of community Social support Effective referrals
	1.3 CIVIC ENGAGEMENT	Voter participation Volunteer engagement
2 FOSTERING CROSS-SECTOR COLLABORATION TO IMPROVE WELL-BEING	2.1 NUMBER AND QUALITY OF PARTNERSHIPS	Local health department collaboration Opportunities to improve health for youth at schools Business support for workplace health promotion and Culture of Health
	2.2 INVESTMENT IN CROSS-SECTOR COLLABORATION	U.S. corporate giving Federal allocations for health investments related to nutrition and indoor and outdoor physical activity
	2.3 POLICIES THAT SUPPORT COLLABORATION	Community relations and policing Youth exposure to advertising for healthy and unhealthy food and beverage products Climate adaptation and mitigation Health in all policies (support for working families)
3 CREATING HEALTHIER, MORE EQUITABLE COMMUNITIES	★ 3.1 BUILT ENVIRONMENT/ PHYSICAL CONDITIONS	Housing affordability Access to healthy foods Youth safety Equity in physical activity opportunities Mobility and transportation
	3.2 SOCIAL AND ECONOMIC ENVIRONMENT	Residential segregation Early childhood education Public libraries
	3.3 POLICY AND GOVERNANCE	Complete Streets policies Air quality
4 STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS	★ 4.1 ACCESS	Access to comprehensive primary care Access to stable health insurance Access to mental health services Routine dental care Collaboration on information sharing
	4.2 CONSUMER EXPERIENCE & QUALITY	Consumer experience Population covered by an ACO/CCO
	4.3 BALANCE AND INTEGRATION	Electronic medical record linkages Hospital partnerships Practice laws for nurse practitioners Social spending relative to health expenditure
OUTCOME	**OUTCOME AREAS**	**MEASURES**
O IMPROVED POPULATION HEALTH, WELL-BEING, AND EQUITY	O.1 ENHANCED INDIVIDUAL AND COMMUNITY WELL-BEING	Well-being rating Caregiving burden
	O.2 MANAGED CHRONIC DISEASE AND REDUCED TOXIC STRESS	Adverse child experiences (ACEs) Disability associated with chronic conditions
	O.3 REDUCED HEALTH CARE COSTS	Family health care cost Potentially preventable hospitalization rates Annual end-of-life care expenditures